

**APPLICATION TO REINSTATE  
KENTUCKY DENTAL HYGINE LICENSE**

**Office Use Only**

Fee Paid \_\_\_\_\_

Date Paid \_\_\_\_\_

**Print name, as you want it to appear on your license.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Name that you retired your license under: \_\_\_\_\_

KY License Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Current Mailing Address:** \_\_\_\_\_  
Street/Box City State Zip

**Address to mail license:** \_\_\_\_\_  
Street/Box City State Zip

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**Current Employer (if applicable) Name:** \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Street/Box City State Zip

**Intended place of Practice (if known) Name:** \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Street/Box City State Zip

**List all states and the license number in which you hold or have held a license:**

State	License Number
_____	_____
_____	_____
_____	_____
_____	_____

Have you had any action or mal-practice claims taken against your license, been placed on probation or convicted of a felony in Kentucky or any other state in the past five (5) years? \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

If yes, please give place, date and circumstances (use additional paper if necessary) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_